COVID-19 Response Checklist for Nursing Homes and other Post-acute Care Settings

Facility Name:	
Address/City/Zip Code:	
E-number (Investigation Number):	
Telephone #:	**Fax #:**
Contact Name:	**Email:**

The following recommendations and reporting requirements are being provided to assist in responding to COVID-19. Facilities may implement additional infection prevention and control measures based on policies and procedures and risk assessment. Facilities should use local and state data to guide infection prevention and control practices during periods of peak circulation.

I. Communication & Reporting		
Response Action	**Date Instituted**	**Notes**
1. Notify facility administration		
2. Notify the facility Medical Director and Infectious Disease Physician (if available)		
3. Notify the facility Infection Preventionist and the individual Certified in Infection Control (CIC) (if available)		
4. Report suspected or confirmed cases to your local health department (LHD) • Identify LHD contacts using the NJDOH – *Local Public Health Directory* http://www.localhealth.nj.gov/ • Review NJDOH *How to Report a Disease* http://www.nj.gov/health/cd/reporting/ • Review NJDOH *Quick Reference Reporting Requirements for Communicable Diseases and Work-related Conditions* https://www.nj.gov/health/cd/documents/reportable_disease_magnet.pdf		
5. Notify staff of the presence of a COVID-19 case and/or outbreak in the facility based on facility policy and procedure		
6. Notify patients/residents and their families, as appropriate, of the presence of a COVID-19 case and/or outbreak in the facility based on facility policies and procedures		
7. Create a line list for **patients/residents**		
8. Create a line list for **staff**		
9. Send the completed line lists and facility floor plan to the LHD		
10. Evaluate personal protective equipment (PPE) supplies		
Note: Facilities must report all lab-confirmed SARS-CoV-2 infections among patients/residents and staff to their LHD (regardless of the current outbreak or investigation status). Facilities should check with their participating laboratory to ensure test results are being reported; any point-of-care testing performed by the facility should be reported directly to their LHD. The line list should include all COVID-19 cases, including symptomatic persons pending testing and persons testing positive by antigen (usually rapid/point of care) or NAAT (usually sent to a lab). Positive results should be included for both symptomatic and asymptomatic cases. CMS requires NHSN Long-term Care Facility COVID-19 Module for nursing homes; however, voluntary reporting to NHSN is encouraged for all facilities.		

II. Screening, Testing, & Response		
Response Action	**Date Instituted**	**Notes**
1. Review outbreak response plans for SARS-CoV-2 and other respiratory pathogens to support containment and response efforts		
2. Review **testing capacity** to identify SARS-CoV-2 in the facility • Identify commercial or public health laboratories that will conduct the test(s), turnaround time, personnel who will collect the specimen(s), the manufacturers' instructions for use, and appropriate specimen collection materials		
Note: The FDA evaluates test characteristics, and facilities should be aware of how tests perform for circulating variants. Refer to FDA *COVID-19 and Medical Devices* https://www.fda.gov/medical-devices/emergency-situations-medical-devices/coronavirus-covid-19-and-medical-devices		
3. **Implement source control measures** as per CDC *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic* https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html.		
Note: CDC recommends implementing source control for persons residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other respiratory outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases of SARS-CoV-2 infection have been identified for 14 days. Additionally, source control is recommended facility-wide or, based on a facility risk assessment, targeted toward higher-risk areas (e.g., emergency departments, urgent care) or patient/resident populations (e.g., when caring for individuals with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission.		
4. **Establish a process to identify individuals entering the facility** who are SARS-CoV-2 positive, symptomatic, or have had close contact with someone with SARS-CoV-2 infection. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g. when to use source control).		
Note: Refer to CDC *Symptoms of COVID-19* for updated symptoms https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. Refer to CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#anchor_1604360721943.		
5. **Educate** visitors about their potential to be exposed to SARS-CoV-2 in the facility		

III. Infection Prevention and Control		
Response Action	**Date Instituted**	**Notes**
1. **Educate** patients/residents, staff, and visitors about SARS-CoV-2, current precautions in place at the facility, and actions they should take to protect themselves (e.g., hand hygiene, vaccination, use of well-fitting source control)		
2. Make all necessary **PPE** available in areas where patient/resident care is provided		

3. Make **waste receptacles** adequately available for discarding used PPE. Position inside the patient/resident room near the exit to make it easy for staff to discard PPE before exiting or before providing care for another patient/resident in the same room		
4. Increase accessibility and ensure the proper functioning of hand hygiene resources in the facility • Provide FDA-approved alcohol-based hand sanitizer with 60–95% alcohol in every patient/resident room, as appropriate (ideally both inside and outside of the room), and other patient/resident care and common areas (e.g., outside the dining hall, in therapy gym) • Ensure sinks are well-stocked with soap and paper towels. Review NJDOH Hand Hygiene in Healthcare Settings https://www.nj.gov/health/cd/documents/topics/NCOV/hand_hygiene_healthcare_settings.pdf		
5. Implement **standard and transmission-based precautions (TBP),** including a NIOSH-approved N95 or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) for patients/residents on empiric TBP and SARS-CoV-2 isolation.		
6. Place appropriate **isolation or TBP signage** outside of the patient/resident(s) room when applicable		
7. **Dedicate** equipment to patients/residents on TBP when possible. If not possible, clean and disinfect equipment following the manufacturer's instructions before use with another patient/resident		
Note: Equipment that cannot be dedicated to a patient/resident should be dedicated to a cohort (e.g., medication carts, mechanical lift, blood pressure machine, environmental cleaning cart).		
8. Review internal **environmental cleaning and disinfection protocols.** Ensure the use of an EPA-registered, hospital-grade disinfectant on List N (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) to clean and disinfect throughout the facility		
9. Conduct audits of routine cleaning and disinfection of **high-touch surfaces and shared medical equipment**		
10. Consider **increasing the frequency** of routine cleaning and disinfection		
11. Prioritize **rounding** in a “well to ill” flow to minimize the risk of cross-contamination (i.e., beginning with standard precaution care areas and working toward TBP rooms, then finally outbreak rooms) when services or equipment are unable to be designated		
12. Identify **Airborne Infection Isolation Rooms or AIIRs (e.g., negative pressure rooms).** If available, AIIRs should be prioritized for patients/residents undergoing aerosol-generating procedures (AGPs) (e.g., cardiopulmonary resuscitation, open suctioning of airways, non-invasive ventilation)		
Note: Refer to CDC *Clinical Questions about COVID-19: Questions and Answers* https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#aerosol for additional information on AGPs. Healthcare personnel (HCP) should wear respiratory protection equivalent to a fitted N95 filtering facepiece respirator or equivalent N95 respirator during aerosol-generating procedures. Staff should doff N95 or equivalent respirators outside the room after exiting the area where the AGP was performed. When respiratory protection is required in an occupational setting, respirators must be used in the context of a comprehensive respiratory protection program that includes fit-testing and training as required under OSHA’s Respiratory Protection standard.		

IV. Contact Tracing or Broad-based Approach		
Response Action	**Date Instituted**	**Notes**
1. Facilities should **perform contact tracing** to identify all high-risk staff exposures and close contact encounters with patients/residents.		
Note: In general, asymptomatic close contacts or HCP with higher-risk exposures do not require empiric TBP or work restrictions, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2. These individuals should still wear source control, and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested. However, facilities may consider the use of empiric TBP or work restrictions when the individual: (1) is unable to be tested or wear source control as recommended for the 10 days following their exposure; (2) is moderate to severely immunocompromised; (3) is residing or working on a unit with others who are moderate to severely immunocompromised; (4) is residing or working on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.		
2. **Contact tracing approach**: Perform SARS-CoV-2 viral testing for all patients/residents identified as close contacts and all staff who have higher-risk exposures, regardless of vaccination status, who have not been previously positive within the past 30 days**. Asymptomatic patients/residents and staff with close contact or higher-risk exposures should have **a series of three viral tests** for SARS-CoV-2 infection. Testing is recommended immediately but not earlier than 24 hours after exposure and, if negative, 48 hours after the first negative test. If negative, again 48 hours after the second negative test. **This will typically be on days 1, 3, and 5 (where the day of exposure is day 0).**		
3. **Continue** performing contact tracing if testing reveals additional cases		
4. **Isolate** and evaluate all symptomatic close contacts and implement **work restrictions** for all symptomatic HCP with higher-risk exposures.		
Note: For the duration of TBP, refer to CDC *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic* https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#anchor_1604360721943.		
Note: A broad-based approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.		
5. **Broad-based approach:** Perform SARS-CoV-2 **testing for all** patients/residents and staff on the affected unit(s), regardless of vaccination status, who have not been previously positive within the past 30 days**immediately and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.		
6. **If additional cases are identified, testing should continue** on the affected unit(s) or facility-wide **every 3-7 days until there are no new cases for 14 days.** If antigen testing is used, more frequent testing (every 3 days) should be considered.		
Note: Source control is recommended for everyone residing, working, or visiting a unit or area of the facility experiencing a SARS-CoV-2 outbreak. The universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days and other criteria for recommending source control are not met.		
7. **Implement empiric TBP** for all patients/residents of an affected unit/area if ongoing transmission is not controlled with initial interventions **until there are no new cases for 14 days.**		

Note: **Re-testing individuals who previously tested positive should be done in accordance with CDC and public health guidance. Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the previous 31-90 days; however, an antigen test instead of a NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.		
V. Patient/Residen Management		
Response Action	**Date Instituted**	**Notes**
1. Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses. Patients/residents should be offered resources and counseled about the importance of receiving the COVID-19 vaccine		
Refer to CDC *Stay Up to Date with Your Vaccines* (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html).		
2. Consider increasing symptom monitoring of patients/residents for fever and other COVID-19 signs and symptoms when a case(s) of COVID-19 is identified.		
3. **Asymptomatic admissions should be managed based on facility policies/procedures.**		
4. When transferring any patient/resident, **notify** the transporting agency and receiving facility of the patient's/resident's infection status.		
Note: SARS-CoV-2 diagnostic test results should be provided (in addition to other pertinent clinical information) to the receiving facility for any transferred patients/residents upon receipt of lab results. Upon identification of a case of COVID-19 in a patient/resident who was recently admitted (within 14 days), the *admitting facility* should provide these results back to the sending facility to allow for the appropriate response and investigation.		
5. Place a patient/resident with suspected or confirmed SARS-CoV-2 infection in a **single-person room**. The door should be kept closed (if safe to do so). Ideally, the patient/resident should have a dedicated bathroom. Patients/residents should remain in their current location if limited single rooms are available.		
Note: Ensure appropriate use of engineering and administrative controls to reduce or eliminate exposures. In some circumstances (e.g., memory care units), keeping the door closed may pose patient/resident safety risks, and the door might need to remain open. If doors must remain open, work with facility engineers (e.g., Maintenance Department) to improve ventilation delivery and minimize airflow into the hallways.		
6. Review the facility **cohorting plan** to guide the safe placement of patients/residents with infectious communicable diseases.		
Note: Only patients/residents with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or the presence of other communicable diseases should also be considered when determining patient/resident placement. If limited single rooms are available, or if numerous patients/residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning COVID-19, patients/residents should remain in their current location. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients/residents with SARS-CoV-2 infection when the number of patients/residents with SARS-CoV-2 infection is high.		

VI. Staff Management		
Response Action	**Date Instituted**	**Notes**
1. Consider implementing universal use of NIOSH-approved N95 or equivalent or higher-level **respirators as source control** for staff		
2. Identify staff who may be at higher risk for severe COVID-19 disease (e.g., immunocompromised) and attempt to assign to unaffected wings/units		
3. **Educate** and train staff on sick leave policies and procedures, including not reporting to work when ill		
Note: Any HCP who develops fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.		
4. Assess staff **competency** on infection prevention and control measures, including return demonstration of donning and doffing PPE		
5. **Bundle** tasks to limit exposures and optimize the supply of PPE		
6. Consider **cross-training** staff to conserve resources		
7. Review or develop staff contingency plans to mitigate anticipated shortages. Refer to CDC *Strategies to Mitigate Healthcare Personnel Staffing Shortages* https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html		

Resources

CDC *Healthcare Workers: Information on COVID-19*
https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

NJDOH *COVID-19*
https://www.nj.gov/health/cd/topics/ncov.shtml

CMS *Coronavirus (COVID-19) Partner Toolkit*
https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit